WEST VIRGINIA Department of Health & Human Resources

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
APPLICATION FOR BENEFITS

The application will be considered if it contains a minimum of the Name, Address, and Signature below. The amount of SNAP benefits will be determined from the date of application. The amount of cash assistance will be determined from the date eligibility requirements are met, including signing the Personal Responsibility Contract (PRC), Self-Sufficiency Plan (SSP), and participating in orientation.

Your Name (first, middle, last)			**Birth Date (Month, Day, Year)**
Mailing Address		**Street Address, if Different**	
City	**State**	**Zip Code**	**Telephone/Message Number During the Day**

HEALTH COVERAGE ONLY

☐ Yes ☐ No	Do you want to get information about this application by email?
	Email address: County:
	Health Care and SNAP: Preferred spoken or written language (if not English):

AUTHORIZED REPRESENTATIVE/LEGAL GUARDIAN/PROTECTIVE PAYEE (HEALTH COVERAGE, SNAP, WV WORKS)

You may appoint someone outside your household to act for your household to make an application and to be interviewed. This person should know your household's situation well enough to give any information needed to determine your eligibility and will include information from your tax returns. You are still responsible for the information that anyone acting as your authorized representative gives, including any information that may be incorrect. If you want to appoint someone for this, write his/her name and address here. For health coverage only, complete Appendix C.

Name: Address:

SNAP EXPEDITED SERVICES

You may receive SNAP benefits within 7 calendar days if: your SNAP household has less than $150 in monthly gross income and liquid resources such as cash, checking or savings accounts are less than or equal to $100; or your rent/mortgage and utilities are more than your household's combined monthly income and liquid resources; or a member of your household is a migrant or seasonal farm worker.

1. How much money do the members of your household have in cash or a bank account? $ _____
2. What is the **total** amount of income you expect your household to receive this month? $ _____
3. What is your **current** monthly rent/mortgage payment? $ _____ Utilities $ _____
4. Is anyone in your household a migrant or seasonal farm worker? ☐ Yes ☐ No

   If yes, answer these questions: Did all of your household income stop recently? ☐ Yes ☐ No

   Does anyone in your household expect to receive income from a new source this month? ☐ Yes How ☐ No

Have you or anyone in your household received or do you expect to receive SNAP benefits from any other state this month?

☐ Yes Where ☐ No

Your Signature	**Date**

DFA-2 (Revised 11/2013)

WEST VIRGINIA Department of Health & Human Resources

APPENDIX A

Health Coverage from Employment

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	4. Employee Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address	6. Employer phone number ( ) -

7. City	8. State	9. Zip
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the name of anyone else who is eligible for coverage from this job.
Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application).

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No
15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
    a. How much would the employee have to pay in premiums for this plan? $ _____
    b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly
16. What change will the employer make for the new plan year (if known)?
    ☐ Employer won't offer health coverage.
    ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
        a. How much would the employee have to pay in premiums for this plan? $ _____
        b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly
        Date of change (mm/dd/yyyy): _____

WEST VIRGINIA Department of Health & Human Resources

EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	4. Employee Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___	
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number ( ) -	
7. City	8. State	9. Zip code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) -	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (continue)

If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (Stop and return this form to employee)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
   a. How much would the employee have to pay in premiums for this plan? $ _____
   b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year (if known)?
   ☐ Employer won't offer health coverage.
   ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
      a. How much would the employee have to pay in premiums for this plan? $ _____
      b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly
      Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B©(2)©(ii) of the Internal Revenue code of 1986).

New 10/13

WEST VIRGINIA Department of Health & Human Resources

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may be special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes,** tribe name ☐ No	☐ Yes **If yes,** tribe name ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program or urban Indian Health program, or through a referral from one of these programs?	☐ Yes ☐ No If **no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If **no,** is this person eligible to get services from the Indian Health Service, tribal health programs or urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties. • Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). • Money from selling things that have cultural significance.	$ _____ How often: _____	**$** _____ How often? _____

New 10/13

WEST VIRGINIA Department of Health & Human Resources

APPENDIX C

Assistance with Completing this Application.

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local DHHR office. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address		3. Apartment or suite number
4. City	5. State	6. Zip code

7. Phone number ( ) -

8. Organization name	ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.	
10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent or broker filling out this application for someone else.

1. Application start date (mm/dd/yyyy)
2. First name, Middle name, Last name & Suffix

3. Organization name	ID number (if applicable)

New 10/13